Correspondence

Laparoscopic Colectomy—An Initial Experience

To the Editor: Using a laparoscope to remove intra-abdominal organs has become increasingly popular in recent years. Laparoscopic removal of gallbladders has proved to be efficacious, although at some increased risk of morbidity.[1] Several authors have suggested that laparoscopy might also be used to remove segments of the colon.[2-4] We would like to share with your readers our initial experience with a consecutive and prospectively evaluated series of colon resections considered for laparoscopic resection. This evaluation was to determine the safety and frequency of this new technique in a routine surgical practice.

A total of 115 consecutive patients requiring colectomy were evaluated for the appropriateness of laparoscopic colectomy. If a patient was actively bleeding, had a colovesical fistula, or required a coloanal or ileoanal anastomosis, the patient was not considered an appropriate candidate for laparoscopic resection. By these criteria, 56 patients were judged inappropriate and 59 had attempted laparoscopic colectomy. Of the attempted procedures, 35 were completed. Laparoscopic resection was abandoned if the exposure was inadequate or if the procedure would be unduly prolonged by this technique. Among the 35 successfully treated patients, estimated blood loss was 184 ml, patients were eating at 1.1 days after the operation, narcotics were required for 1.7 days, and patients were discharged 3.7 days after laparoscopic colectomy. Complications included three cases of postoperative wound infection, one patient with intraoperative bleeding, and one with an anastomotic leak.

These data compare favorably with those of traditional techniques in terms of length of hospital stay. Substantial cost savings may be possible in those operations that are completed laparoscopically. We also learned that this procedure can be done in a reasonable period of time. In addition, we believe that the requirements for pain medication are decreased.

This experience is preliminary, and long-term follow-up is necessary to assess the adequacy of cancer resection and the incidence of long-term complications. At this point, however, it appears that in selected patients, laparoscopic removal of portions of the colon offers practical advantages to patients.

ROBERT W. BEART Jr. MD
Department of Surgery
USC School of Medicine
Los Angeles, CA 90033-4612

RICHARD T. SCHLINKERT, MD
Assistant Professor of Surgery
Mayo Clinic Scottsdale
Scottsdale, Arizona

REFERENCES

1. Southern Surgeons Club: A prospective analysis of 1,518 laparoscopic cholecystectomies. N Engl J Med 1991; 324:1073-1078

2. Saclarides TJ, Ko ST, Airan M, Dillon C, Franklin, J: Laparoscopic removal of a large colonic lipoma—Report of a case. Dis Colon Rectum 1991; 34:1027-1029

3. Schlinkert RT: Laparoscopic-assisted right hemicolectomy. Dis Colon Rectum 1992; 34:1030-1031

4. Jacobs M, Verdeja JC, Goldstein HS: Minimally invasive colon resection. Surg Laparosc Endosc 1991; 1:144-150

Recurrent Hyperthermia Due to Lovastatin

To the Editor: Lovastatin, an inhibitor of hydroxymethylglutaryl coenzyme A (HMG-CoA), is a well-tolerated and effective treatment of hypercholesterolemia. Commonly reported adverse reactions include asymptomatic elevations of aminotransferase values, gastrointestinal disturbances, headache, myalgia, and rash.[1,2] We report a case of a patient with recurrent episodes of hyperthermia due to lovastatin therapy.

Report of a Case

The patient, a 55-year-old woman with Parkinson's disease, rheumatoid arthritis, hypothyroidism, and hypercholesterolemia, was admitted to Loma Linda (California) University Medical Center with a temperature of 40.5° C. She presented after two weeks of low-grade fevers treated with oral erythromycin. She was also taking furosemide, a combination drug containing levodopa and carbidopa, levothyroxene sodium, and lovastatin. She was somnolent, responded to deep pain with purposeful movements, and had cogwheel rigidity. Laboratory tests elicited the following values: serum sodium, 120 mmol per liter; potassium, 3.0 mmol per liter; chloride, 92 mmol per liter; and bicarbonate, 30 mmol per liter. A complete blood count and coagulation profile, including platelets, were normal. Cultures of blood, urine, sputum, and cerebrospinal fluid specimens were negative for pathogens. A serum thyroid-stimulating hormone level was normal. Chest radiography and computed tomography of the head were normal.

Therapy with furosemide, erythromycin, and lovastatin was discontinued. Potassium chloride and a saline solution were administered. After 48 hours her fever resolved, her mental state was normal, and electrolytes returned to normal. Three months later she was seen with an identical historical, physical, and metabolic profile treated with ofloxacin. An antinuclear antibody titer was 1:64 and a Westergren sedimentation rate was 39 mm per hour. Therapy with ofloxacin and lovastatin was discontinued. After 48 hours, her mental state returned to normal and her fever resolved. A month later she was seen a third time with the same findings. Serial cardiac enzyme levels had a normal MB fraction, but her total creatinine kinase value was elevated at 543 units per liter. The lovastatin therapy was again discontinued. After 72 hours, her fever again resolved and her mental state became normal. In the first 12 months with discontinuation of the lovastatin, she has had no further hyperthermic episodes.

Discussion

Inhibitors of HMG-CoA are widely used for the treatment of hypercholesterolemia. Lovastatin has been available in the United States since 1987, and its safety and efficacy have been well established in both short- and long-term use.[3] Although fever has been reported in a few